

## **COMBINED HORMONAL CONTRACEPTION CONSENT FORM**

I, (print or type name) \_\_\_\_\_,  
request Combined Hormonal Contraceptives as my family planning method.

- ☐ I have received educational materials as well as the patient package insert that explains the, benefits and risks of using \_\_\_\_\_ which is the type of combined hormonal contraception I have selected.
- ☐ I understand that no birth control method is perfect and that some women have gotten pregnant while on the CHC (3 out of every 1000 women during the first year of perfect use).
- ☐ I understand CHCs will not protect me from sexually transmitted infections and that I need to use condoms for protection from these infections.
- ☐ I understand that certain medicines may interact with the CHC to decrease the effectiveness of the CHC. I know it is important to tell all my health care providers that I am on the CHC.
- ☐ I understand that while using the CHC the chances of developing health problems increase with certain conditions such as:
- Cigarette smoking
  - High cholesterol
  - Age 35 or older
  - Diabetes
  - High blood pressure
- ☐ I understand that it is important to tell my health care provider if I have ever had any of the following conditions before taking the CHC
- Blood clots in the lungs, legs, or brain
  - Unexplained bleeding from the vagina
  - Inflammation of the veins
  - Cancer of the breast or uterus
  - Liver disease
  - Heart disease or stroke
- ☐ I understand that side effects sometimes associated with the CHC include:
- Nausea and vomiting
  - Weight gain or loss
  - Breast tenderness
  - Spotting between periods

☐ I know to watch for "A.C.H.E.S." as danger signals and to contact a health care provider immediately if these signs occur:

- Abdominal pains
- Chest pains or shortness of breath
- Headaches (severe), numbness, or dizziness
- Eye problems such as blurred vision or double vision
- Severe leg pain

☐ I have had a chance to ask questions and have had my questions answered.

Date: Client Signature:

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Please complete the following if interpretation of informed consent was required:

An interpreter was offered to the client. ☐ yes ☐ no

This form has been read to the client in the client's spoken language. ☐ yes ☐ no

Patient's Language (specify):

Interpreter's Name: (print or type name of interpreter)

Interpreter Services provided by (agency):

Date: Interpreter Signature:

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Staff Use Only:

By my signature I affirm that:

- ☐ The client has read this form or had it read to her by an interpreter.
- ☐ The client states that she understands this information.
- ☐ The client has indicated that she has no further questions.

Date: Staff Signature:

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